		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0010678

Facility Name: Winchester House

Address: 1125 N. Milwaukee Ave (Number) Libertyville (City) 60048-1399 (Zip Code)

County: Lake

Telephone Number: 847-377-7236 **Fax #** 847-816-5176

IDPA ID Number: 36 6006600

Date of Initial License for Current Owners: Before 1941

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Joan Bodenlos **Telephone Number:** 847-5186

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/99 to 11/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Stephen Nussbaum

(Title) Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) 847-377-7341 Fax # 847-816-5168

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	360	Skilled (SNF)	360	131,400	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	360	TOTALS	360	131,400	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,508	2,749	144	10,401	8
9	SNF/PED					9
10	ICF	79,258	37,189	1,132	117,579	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	86,766	39,938	1,276	127,980	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.40%

D. How many bed-hold days during this year were paid by Public Aid?
565 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Employee meals, Non-Resident Laundry

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started Before 1941

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 144

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [ ] MODIFIED CASH* [X] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [n/a]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	1,012,017	65,162	30,340	1,107,519		1,107,519		1,107,519			1
2	Food Purchase		541,501		541,501	(44,873)	496,628		496,628			2
3	Housekeeping	691,909	80,219	14,093	786,221		786,221	(879)	785,342			3
4	Laundry	372,420	17,020	47,243	436,683		436,683	(18,128)	418,555			4
5	Heat and Other Utilities			433,928	433,928		433,928	0	433,928			5
6	Maintenance	576,066	136,186	271,999	984,251		984,251	0	984,251			6
7	Other (specify):*							0				7
8	TOTAL General Services	2,652,412	840,088	797,603	4,290,103	(44,873)	4,245,230	(19,007)	4,226,223			8
	B. Health Care and Programs											
9	Medical Director					15,450	15,450	0	15,450			9
10	Nursing and Medical Records	6,160,703	431,603	175,057	6,767,363	(122,195)	6,645,168	(1,138)	6,644,030			10
10a	Therapy	295,831	1,644	43,033	340,508		340,508	0	340,508			10a
11	Activities	354,973	17,087	1,248	373,308		373,308	0	373,308			11
12	Social Services	153,849	349	2,144	156,342		156,342	0	156,342			12
13	Nurse Aide Training	90,484			90,484	18,512	108,996		108,996			13
14	Program Transportation					5,397	5,397	0	5,397			14
15	Other (specify):*	110,832	643	638	112,113		112,113	0	112,113			15
16	TOTAL Health Care and Programs	7,166,672	451,326	222,120	7,840,118	(82,836)	7,757,282	(1,138)	7,756,144			16
	C. General Administration											
17	Administrative	107,165			107,165		107,165	0	107,165			17
18	Directors Fees							0				18
19	Professional Services							0				19
20	Dues, Fees, Subscriptions & Promotions			20,795	20,795	890	21,685	0	21,685			20
21	Clerical & General Office Expenses	501,810	32,128	124,104	658,042	(890)	657,152	(381)	656,771			21
22	Employee Benefits & Payroll Taxes			1,308,656	1,308,656	44,873	1,353,529	2,202,215	3,555,744			22
23	Inservice Training & Education							0				23
24	Travel and Seminar			47,589	47,589	(23,909)	23,680	(12,862)	10,818			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			79,060	79,060		79,060	0	79,060			26
27	Other (specify):*				439,265		439,265	0	439,265			27
28	TOTAL General Administration	608,975	32,128	1,580,204	2,660,572	20,964	2,681,536	2,188,972	4,870,508			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,428,059	1,323,542	2,599,927	14,790,793	(106,745)	14,684,048	2,168,827	16,852,875			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							619,636	619,636			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							0				32
33	Real Estate Taxes							0				33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	**TOTAL Ownership**							619,636	619,636			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers	143,092	781,009	619	924,720	28,764	953,484	(1,116)	952,368			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			196,553	196,553		196,553	0	196,553			42
43	Other (specify):* oxygen					77,981	77,981	0	77,981			43
44	**TOTAL Special Cost Centers**	143,092	781,009	197,172	1,121,273	106,745	1,228,018	(1,116)	1,226,902			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	10,571,151	2,104,551	2,797,099	15,912,066	0	15,912,066	2,787,347	18,699,413			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(18,128)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(16,376)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (34,504)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	2,202,215		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,202,215		36
37	**(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))**	$ 2,167,711		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		127	10	42
43	Prescription Drugs					43
44	Exceptional Care Program	X		28,637	10	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 28,764		47

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.
2. Push the Print Other Adjustments button.

STATE OF ILLINOIS **Page 5A**

Facility Name: Winchester House

ID#: 0010678

Report Period Beginning: 12/01/99

Ending: 11/30/00

Print Other Adjustments

The information listed in B13 thru G43 is from Page 5.

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
1	Day Care	0	0	Line 1	0
2	Other Care for Outpatients	0	0	Line 2	0
3	Governmental Sponsored Special Programs	0	0	Line 3	0
4	Non-Patient Meals			Line 4	(18,128)
5	Telephone, TV & Radio in Resident Rooms	0	0	Line 5	0
6	Rented Facility Space	0	0	Line 6	0
7	Sale of Supplies to Non-Patients	0	0	Line 7	0
8	Laundry for Non-Patients	(18,128)	4	Line 8	(18,128)
9	Non-Straightline Depreciation	0	0	Line 9	0
10	Interest and Other Investment Income	0	0	Line 10	0
11	Discounts, Allowances, Rebates & Refunds	0	0	Line 10a	0
12	Non-Working Officer's or Owner's Salary	0	0	Line 11	0
13	Sales Tax	0	0	Line 12	0
14	Non-Care Related Interest	0	0	Line 13	0
15	Non-Care Related Owner's Transactions	0	0	Line 14	0
16	Personal Expenses (Including Transportation)	0	0	Line 15	0
17	Non-Care Related Fees	0	0	Line 16	0
18	Fines and Penalties	0	0	Line 17	0
19	Entertainment	0	0	Line 18	0
20	Contributions	0	0	Line 19	0
21	Owner or Key-Man Insurance	0	0	Line 20	0
22	Special Legal Fees & Legal Retainers	0	0	Line 21	0
23	Malpractice Insurance for Individuals	0	0	Line 22	0
24	Bad Debt	0	0	Line 23	0
25	Fund Raising, Advertising and Promotional	0	0	Line 24	0
26	Income & IL Personal Property ReplacementTaxes	0	0	Line 25	0
27	Nurse Aide Training for Non-Employees	0	0	Line 26	0
28	Yellow Page Advertising	0	0	Line 27	0
29	Non-Paid Workers	0	0	Line 28	0
30	Donated Goods	0	0	Line 29	(18,128)
31	Amortization Expense	0	0	Line 30	0
32				Line 31	0
33				Line 32	0
34				Line 33	0
35				Line 34	0
36				Line 35	0
37				Line 36	0
38				Line 37	0
39				Line 38	0
40				Line 39	0
41				Line 40	0
42				Line 41	0
43				Line 42	0
44				Line 43	0
45				Line 44	0
46				Line 45	(18,128)
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Reference Reference

1 2 3 4 5 6 7 9 10 10a 11 12 13 14 15 17 18 19 20 21 22 23 24 25 26 27 30 31 32 33 34 35 36 38 39 40 41 42 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Winchester House **#** 0010678 **Report Period Beginning:** 12/01/99 **Ending:** 11/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(18,128)	0	0	0	0	0	0	0	0	0	0	(18,128)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(18,128)	0	0	0	0	0	0	0	0	0	0	(18,128)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	2,202,215	0	0	0	0	0	0	0	0	0	2,202,215	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	2,202,215	0	0	0	0	0	0	0	0	0	2,202,215	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(18,128)	2,202,215	0	0	0	0	0	0	0	0	0	2,184,087	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(18,128)	2,202,215	0	0	0	0	0	0	0	0	0	2,184,087	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number Winchester House # 4910678 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
County of Lake	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	Line	2	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization: Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6	
1	V	22	FICA	0	County of Lake	100.00%	765,727	= 765,727	1	765727	1
2	V	22	IMRF	0	County of Lake	100.00%	896,472	896,472	2	896472	2
3	V	22	Workmans Compensation	0	County of Lake	100.00%	397,658	397,658	3	397658	3
4	V	22	Unemployment Insurance	0	County of Lake	100.00%	63,298	63,298	4	63298	4
5	V	22	Liability Insurance	0	County of Lake	100.00%	79,860	79,860	5	79860	5
6	V								6		6
7	V								7		7
8	V								8		8
9	V								9		9
10	V								10		10
11	V								11		11
12	V								12		12
13	V								13		13
14	Total			0			2,202,215	= 2,202,215	14		14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not Applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8D] [Show Pgs 8E thru 8I] [Hide Pgs 8A thru 8I]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: County of Lake
Street Address: 18 North County St
City / State / Zip Code: Waukegan, IL 60085
Phone Number: (847)3606601
Fax Number: (847)3606592

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Indirect Costs	Direct Cost			$ 610,818	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 610,818	$		$	25

Print Preview

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Not Applicable						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	Not Applicable	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 189,077 B. General Construction Type: Exterior Brick Frame Fire Resistant Number of Stories 5

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		522,720	Prior 1941	$ 5,466	1
2					2
3	TOTALS	522,720		$ 5,466	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	360		1972	1971	$ 5,306,095	$ 132,654	40	$ 132,654	$ 0	$ 3,585,454	4
5	0		1960	1959	503,487	0	40	0		503,487	5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Expansion			1972	31,454	786	40	786		22,804	9
10	Dishroom Addition			1978	44,855	1,121	40	1,121		25,791	10
11	Concrete Stoop			1982	875	35	25	35		665	11
12	Smoke Detectors			1982	7,260	290	25	290		5,517	12
13	Roofing Improvement			1984	41,875	1,675	25	1,675		28,475	13
14	Vestibule Improvement			1984	41,321	1,033	40	1,033		17,561	14
15	Air Conditioning			1986	1,764,063	117,604	15	117,604		1,764,063	15
16	Storage Building			1987	9,986	499	20	499		6,990	16
17	Sprinkler System			1987	51,732	2,069	25	2,069		28,970	17
18	Reroof Building A			1987	15,393	770	20	770		10,775	18
19	Repipe Steamline			1987	22,270	891	25	891		12,471	19
20	Redecorate Hallways			1987	105,483	4,219	25	4,219		59,070	20
21	Dining Room Alteration			1987	120,602	4,824	25	4,824		67,537	21
22	Folding Gate			1987	1,961	131	15	131		1,831	22
23	Boiler Renovation			1988	11,600	464	25	464		6,032	23
24	Parking Lot Expansion			1988	50,384	3,359	15	3,359		43,666	24
25	Steel Doors			1989	9,300	620	15	620		7,440	25
26	AirConditioning 2nd Floor			1989	30,435	2,029	15	2,029		24,348	26
27	Parkingm Lot Expansion			1989	6,121	408	15	408		4,897	27
28	Smoke Dampers			1989	27,520	1,835	15	1,835		22,016	28
29	AirConditioning 3rd Floor			1990	49,807	3,320	15	3,320		36,525	29
30	Flooring			1990	6,200	413	15	413		4,546	30
31	Electrical Improvement			1990	7,925	528	15	528		5,811	31
32	Asbestos Removal			1990	29,985	1,999	15	1,999		21,989	32
33	Nursing Station			1990	40,995	2,733	15	2,733		30,063	33
34	Folding Walls			1990	13,880	925	15	925		10,178	34
35	Plumbing Improvement			1991	20,830	1,042	20	1,042		10,416	35
36	TOTAL (lines 4 thru 35)				$ 8,373,694	$ 288,276		$ 288,276	$	$ 6,369,388	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Elevator Improvement			1991	61,252	3,063	20	3,063		30,626	9
10	Flooring			1991	6,419	642	10	642		6,419	10
11	Electric Lock System			1992	21,565	2,157	10	2,157		19,409	11
12	Roofing - Laundry Area			1992	43,283	2,164	20	2,164		19,477	12
13	Aluminum Siding - Building A			1992	8,301	553	15	553		4,980	13
14	Electrical Improvement			1993	50,219	3,348	15	3,348		26,784	14
15	Fire Alarm System			1993	239,881	11,994	20	11,994		83,958	15
16	Nurse Call System			1994	106,546	7,103	15	7,103		49,721	16
17	Windows			1995	34,949	2,330	15	2,330		13,980	17
18	Fire Alarm Improvement			1995	8,473	847	10	847		5,084	18
19	Parking Lot Improvement			1995	5,246	350	15	350		2,099	19
20	Roofing - Kitchen Area			1995	87,905	4,395	20	4,395		26,371	20
21	Roofing - Building B			1995	43,433	2,172	20	2,172		13,030	21
22	Electrical Upgrade			1995	12,081	1,208	10	1,208		7,249	22
23	5th Floor Nursing Station Remodeling			1995	21,392	2,139	10	2,139		12,835	23
24	Elevator Upgrade			1995	21,865	1,093	20	1,093		6,559	24
25	Flooring Shower Room			1995	8,238	549	15	549		3,295	25
26	Fire Doors			1995	3,132	157	20	157		940	26
27	Computer Cabling			1996	10,804	1,080	10	1,080		5,402	27
28	Floors - Dishroom, Storage Room			1996	31,221	2,081	15	2,081		10,407	28
29	Magnetic Door Locks			1996	6,122	612	10	612		3,061	29
30	Elevator Upgrade			1996	16,500	825	20	825		4,125	30
31	Deaerating Feed Tank			1996	18,600	744	25	744		3,720	31
32	Asphalt Patching			1996	3,462	231	15	231		1,154	32
33	Door Replacement			1996	2,600	173	15	173		866	33
34	Removal of Trees/Add Sod			1996	2,450	98	25	98		490	34
35	5th Floor Heat Upgrade			1996	8,760	584	15	584		2,920	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 52,692		$ 52,692	$	$ 364,961	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Caulk/Tuckpoint Windows			1996	80,576	4,029	20	4,029		20,144	9
10	Flashing - Building B			1996	4,248	283	15	283		1,416	10
11	Door Alarms			1997	14,222	1,422	10	1,422		5,689	11
12	Walk in Refridgerator Remodeling			1997	9,500	475	20	475		1,900	12
13	Elevator Remodeling			1997	7,747	516	15	516		2,065	13
14	Heat Controls Upgrade			1997	6,637	442	15	442		1,769	14
15	Nursing Station Remodeling			1997	19,000	1,267	15	1,267		5,067	15
16	Roof Repair			1997	3,000	200	15	200		800	16
17	Dryer Filtration System			1997	39,877	1,994	20	1,994		7,976	17
18	Tile Replacement - Building A - Admin			1997	2,401	240	10	240		960	18
19	Nursing Station Remodeling			1998	24,122	1,608	15	1,608		4,824	19
20	Boiler Upgrade			1998	54,840	2,742	20	2,742		8,226	20
21	Roof Repair			1998	65,060	4,337	15	4,337		13,012	21
22	Shower Room Floor Repair			1998	39,985	2,666	15	2,666		7,997	22
23	5th Floor Remodeling			1999	98,119	6,541	15	6,541		13,082	23
24	Boiler Upgrade			1999	12,000	600	20	600		1,200	24
25	Security System Upgrade			1999	6,930	693	10	693		1,386	25
26	Concrete Repair			1999	5,000	333	15	333		666	26
27	Plumbing Upgrade			1999	5,000	250	20	250		500	27
28	Courtyard Remodeling			1999	30,000	2,000	15	2,000		4,000	28
29	Landscaping			1999	5,000	333	15	333		666	29
30	Elevator Upgrade			1999	4,200	280	15	280		560	30
31	Smoke Dampers			1999	47,760	3,184	15	3,184		6,368	31
32	Resident room remodeling			2000	23,406	1,560	15	1,560		1,560	32
33	Medical room remodeling			2000	11,508	767	15	767		767	33
34	Rooftop heater			2000	9,940	994	10	994		994	34
35	Windows laundry			2000	8,264	826	10	826		826	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 40,582		$ 40,582	$	$ 114,420	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Magnetic locks			2000	6,750	675	10	675		675	9
10	Wandering system			2000	27,929	2,793	10	2,793		2,793	10
11	TV Satellite system			2000	20,398	2,039	10	2,039		2,039	11
12											12
13											13
14											14
15											15
16											16
17											17
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30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 5,507		$ 5,507	$	$ 5,507	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
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30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 2,257,825	$ 206,046	$ 206,046	$	various	$ 743,397	37
38	Current Year Purchases	147,081	16,666	16,666		various	16,666	38
39	Fully Depreciated Assets	25,427					25,427	39
40								40
41	TOTALS	$ 2,430,333	$ 222,712	$ 222,712	$		$ 785,490	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident/Employee	97 Dodge Caravan	1997	$ 16,433	$ 3,287	$ 3,287	$	5	$ 13,148	42
43	Resident	97 Chevy Van	1997	32,900	6,580	6,580		5	26,320	43
44	Maintenance	93 Dodge Pickup	1992	17,823	0	0		5	17,823	44
45										45
46	TOTALS			$ 67,156	$ 9,867	$ 9,867	$		$ 57,291	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 12,454,767	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 619,636	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 619,636	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 7,697,057	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Building	$ 180,634	$	$ 180,634	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 180,634	$	$ 180,634	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 92

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 48

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$ 18,512	$ 18,512
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)		128,012		128,012
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 128,012	$ 18,512	$ 146,524
10	SUM OF line 9, col. 1 and 2 (e)	$ 128,012			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	15
2. From other facilities (f)	0
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	0
TOTAL TRAINED	16

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units		Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3		hrs	$	355	$	7,027	$	355	$ 7,027	1
2	Licensed Speech and Language Development Therapist	10a-3		hrs		49		735		49	735	2
3	Licensed Recreational Therapist			hrs								3
4	Licensed Physical Therapist	10a-3		hrs		2,248		35,271		2,248	35,271	4
5	Physician Care			visits								5
6	Dental Care			visits								6
7	Work Related Program			hrs								7
8	Habilitation			hrs								8
9	Pharmacy	39	75,499	# of prescrpts	143,092				781,009	75,499	924,101	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10
11	Academic Education			hrs								11
12	Exceptional Care Program	39-8			25,137				3,627		28,764	12
13	Other (specify):	43-8							99,792		99,792	13
14	TOTAL				$ 168,229	2,652	$	43,033	$ 884,428	78,151	$ 1,095,690	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,294,915	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Petty Cash	250		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,295,165	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	0		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,295,165	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 177,710	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	387,023		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 564,733	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,730,432		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,730,432	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,295,165	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (292,663)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,002,502	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(292,663)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (292,663)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (292,663)	24 *

*** This must agree with page 17, line 47.**

Print Preview

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,874,386	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,874,386	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	37,555	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 37,555	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	6,809	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	35,332	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	716,971	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	18,128	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 777,240	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	440,291	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 440,291	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	County Tax Levy	475,035	28
28a	Miscellaneos Revenue	14,896	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 489,931	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,619,403	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 4,183,083	31
32	Health Care	7,724,131	32
33	General Administration	2,837,419	33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers	970,880	35
36	Provider Participation Fee	196,553	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,912,066	40
41	**Income before Income Taxes (line 30 minus line 40)****	(292,663)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (292,663)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? n/a If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,120	$ 83,828	$ 39.54	1
2	Assistant Director of Nursing	1,816	2,116	72,255	34.15	2
3	Registered Nurses	68,570	76,938	2,020,720	26.26	3
4	Licensed Practical Nurses	27,718	32,529	766,975	23.58	4
5	Nurse Aides & Orderlies	223,767	253,310	2,954,002	11.66	5
6	Nurse Aide Trainees	3,704	3,804	34,897	9.17	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	15,995	19,851	295,831	14.90	8
9	Activity Director	1,994	2,220	44,131	19.88	9
10	Activity Assistants	28,442	32,497	332,205	10.22	10
11	Social Service Workers	7,200	8,356	177,586	21.25	11
12	Dietician	1,806	2,244	42,683	19.02	12
13	Food Service Supervisor	9,277	11,231	284,072	25.29	13
14	Head Cook	9,925	11,389	150,174	13.19	14
15	Cook Helpers/Assistants	40,582	45,488	487,011	10.71	15
16	Dishwashers					16
17	Maintenance Workers	31,515	36,073	633,144	17.55	17
18	Housekeepers	77,015	90,812	955,385	10.52	18
19	Laundry	35,304	29,968	302,845	10.11	19
20	Administrator	2,080	2,080	107,165	51.52	20
21	Assistant Administrator	2,080	2,080	64,670	31.09	21
22	Other Administrative	1,840	2,080	71,206	34.23	22
23	Office Manager					23
24	Clerical	37,298	42,005	415,883	9.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,016	2,208	53,777	24.36	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,876	4,598	77,614	16.88	31
32	Other Health Care(specify)					32
33	Other(specify) Pharmacy	5,696	6,283	143,092	22.77	33
34	TOTAL (lines 1 - 33)	641,596	722,280	$ 10,571,151 *	$ 14.64	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	120	15,504	9-5	36
37	Medical Records Consultant	96	3,928	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1,148	35,271	10a-3	40
41	Occupational Therapy Consultant	355	7,027	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	49	735	10a-3	43
44	Activity Consultant	12	1,248	11-3	44
45	Social Service Consultant	48	2,144	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,828	$ 65,857		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,862	$ 71,428	10-3	50
51	Licensed Practical Nurses	81	2,501	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,943	$ 73,929		53

Print Preview

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Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Stephen Nussbaum	Administrator	0.00%	$ 107,165
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 107,165

B. Administrative - Other

Description	Amount
	$
NONE	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
		$
NONE		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 397,698
Unemployment Compensation Insurance	63,298
FICA Taxes	765,727
Employee Health Insurance	1,308,656
Employee Meals	35,332
Illinois Municipal Retirement Fund (IMRF)*	896,472
Liability insurance	79,060
TOTAL (agree to Schedule V, line 22, col.8)	$ 3,546,243

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
NONE		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 74)	890
See Attached	20,795
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,685

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 12,862
In-State Travel	10,818
See Attached	
Seminar Expense	
Entertainment Expense	(12,862)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,818

**See instructions.

Print Preview

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Print Preview

Facility Name & ID Number Winchester House # 0010678 Report Period Beginning: 12/01/99 Ending: 11/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Attached**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **15 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **123,683** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **196,553**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **35,332** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Miller & Cooper** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not completed at this time**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview